

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/08/2010
NAME OF PROVIDER OR SUPPLIER HENDERSON HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1180 E. LAKE MEAD DRIVE HENDERSON, NV 89015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on July 8, 2010, and finalized on July 8, 2010, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. Complaint #NV0025397 was substantiated. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000			
F 284 SS=D	The following deficiencies were identified: 483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a post discharge plan of care was developed with the facility staff and resident/family for 1 of 2 sampled residents (Resident #1). Findings include:	F 284			7/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 284	<p>Continued From page 1</p> <p>Resident #1 was admitted on 5/6/10, with diagnoses including syncope, fractured wrist, and debility. Documentation in Resident #1's record indicated the resident had a peripherally inserted central catheter (PICC) line in the right upper arm. Review of Resident #1's medication administration record for May 2010, indicated the intravenous access had not been used to provide medications for ten days prior to the resident's discharge on 5/17/10.</p> <p>Documentation in Resident #1's record indicated a discharge plan that the resident would be discharged to a group home with home health services. There was no documentation on the Case Management Admission and Discharge Assessment of a PICC line in place. There was no documentation of a PICC line on the referral form signed by the physician and faxed by the facility to the home health agency.</p> <p>The facility discharged Resident #1 on 5/17/10, to a group home with a PICC line in place without physician's orders or documented medical necessity.</p> <p>On 7/8/10 at 2:45 PM, Employee #4 stated the employee was unaware Resident #1 had a PICC line in place when the employee made the arrangements for the resident to be discharged to a group home.</p>	F 284			